MOMS Nurse Practitioner

(Referral arrangement with HSS)

Category of Service 0469 - Specialty Code 159 on file; and must be entered on claim

Procedure Code	Description	Maximum Fee
New 59425*****	Antepartum care only; **4-6 visits (**includes reimbursement for one initial antepartum encounter **($69.00)** and five subsequent encounters **($59.00)**. If less than 6 antepartum encounters were provided, adjust the amount charged accordingly**)**.	364
New 59426*****	Antepartum care only; **7 or more visits (**includes reimbursement for one initial antepartum encounter **($69.00)** and eight subsequent encounters **($59.00)**. If less than 9 antepartum encounters were provided, adjust the amount charged accordingly. For 6 or less antepartum encounters, see code 59425**.)**	541
59430	Postpartum care only (outpatient) (separate procedure)	59

- Providers should bill the appropriate code after <u>all</u> antepartum care has been rendered using the last antepartum visit as the date of service.

Sample 5

MOMS NURSE PRACTITIONER – REFERRAL ARRANGEMENT WITH HSS

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM — TITLE XIX PROGRAM

EMERGENCY OF SERVICE: 0469 | SPECIALTY CODE: 159 | ONLY TO BE USED TO ADJUST/VOID A ID CLAIM: CODE A V | ORIGINAL CLAIM REFERENCE NUMBER:

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name): Sara Green
2. PATIENT'S BIRTH DATE: 73
2A. TOTAL ANNUAL FAMILY INCOME
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. PATIENT'S SEX: MALE ☐ FEMALE ☒ X
5A. INSURED'S SEX: MALE ☐ FEMALE ☐
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: B|N|5|2|5|1|3|T
6B. PATIENT'S TELEPHONE NUMBER: ( )
8B. PRIVATE INSURANCE NUMBER
GROUP NO.
RECIPROCITY NO.
8C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT ☐ CRIME VICTIM ☐ AUTO ACCIDENT ☐ OTHER LIABILITY ☐
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION
15. FIRST CONSULTED FOR CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES ☐ NO ☐
16A. EMERGENCY RELATED: YES ☐ NO ☐
17. DATE PATIENT MAY RETURN TO WORK
18. DATES OF DISABILITY: TOTAL ☐ PARTIAL ☐ FROM TO
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19A. ADDRESS (OR SIGNATURE SHP ONLY)
19B. TYP
19C IDENTIFICATION NUMBER
20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED
20A. NAME OF HOSPITAL
20B. SURGERY DATE
20C. TYPE OF SURGERY
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES ☐ NO ☐
LAB CHARGES
23A. SERVICE PROVIDER NAME
23B. Type
23C. IDENTIFICATION NUMBER
23D. EPSDT OTHP
23E. STERILIZATION ABORTION CODE: 0
23F. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS: RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24F BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
1.
2.
3.
23G. POSSIBLE DISABILITY: YES ☐ X NO
23H. PNCP: YES ☐ NO ☐
23I. FAMILY PLANNING: YES ☐ X NO
23A. PREOK APPROVAL NUMBER
23B. PRIOR SOURCES (2)

24A. DATE OF SERVICE	24B. PLACE	24C. TYPE	24D. SOURCE CODE / PROCEDURE (CPT)	MOD.	MOD.	24E. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE SHOWN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	24F. SOURCE CODE / DIAGNOSIS CODE	24G. DAYS OR UNITS	24H. CHARGES	24I.	24J.
07 | 01 | 02	1		5|9|4|2|5			Antepartum care – 3 visits 1-initial, 2 subsequent visits	V|2|2|1		$187 00		
07 | 28 | 02	1		5|9|4|3|0			Postpartum care only	V|2|2|1		59 00		

24K. INPATIENT HOSPITAL VISITS: FROM THROUGH
24L. PROCEDURE CODE
24M. MOD.
25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.): Rachael Snow
26. ACCEPT ASSIGNMENT: YES ☐ NO ☐
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER

Rachael Snow
2300 West End Ave.
Anytown, NY 12205

25A. PROVIDER IDENTIFICATION NUMBER: 02215263
26B. DATE SIGNED: 07 | 30 | 02
25C. MEDICAID GROUP IDENTIFICATION NUMBER
25D. LOCATOR CODE: 0 | 3
25E. SA EXCP CODE
COUNTY OF SUBMITTAL
INVOICE NUMBER: 44362 4558

- **Antepartum Care ONLY** – 3 encounters – provider *must* reduce the maximum reimbursement fee to reflect the correct payment
- **Postpartum Care ONLY** .